

Prospect Primary OSHC  
Enrolment Form: Part 127 Gladstone Road, Prospect SA 5082, AU  
Ph: 0456 966 460Fax: 8344 2993  
prospect.oshc@schools.sa.edu.au

## CHILD

Family Name:	<input type="text"/>	Gender:	<input type="text"/>
First Name(s):	<input type="text"/>	Known as:	<input type="text"/>
Date of birth:	<input type="text"/>	CRN:	<input type="text"/>
Address No. / Street:	<input type="text"/>	Town/ Suburb:	<input type="text"/>
Postcode:	<input type="text"/>	Primary Language:	<input type="text"/>
Indigenous status:	Aboriginal:	Yes / No	TS Islander:
			Yes / No

## ELIGIBLE PARENT/GUARDIAN &amp; BILLING DETAILS

Name:	<input type="text"/>		
Date of birth:	<input type="text"/>	CRN:	<input type="text"/>
Relationship to child:	<input type="text"/>	Contact Priority:	<input type="text"/>
		Primary Language:	<input type="text"/>
Address: (h)	<input type="text"/>		
(w)	<input type="text"/>		
Phone: (h)	<input type="text"/>	(w)	<input type="text"/>
(m)	<input type="text"/>		<input type="text"/>
Email:	<input type="text"/>		

## OTHER PARENT/GUARDIAN (if applicable)

Name:	<input type="text"/>		
Relationship to child:	<input type="text"/>	Contact Priority:	<input type="text"/>
		Primary Language:	<input type="text"/>
Address: (h)	<input type="text"/>		
(w)	<input type="text"/>		
Phone: (h)	<input type="text"/>	(w)	<input type="text"/>
(m)	<input type="text"/>		<input type="text"/>
Email:	<input type="text"/>		

## PARENTING PLANS / ORDERS relating to this child


## EMERGENCY CONTACTS &amp; COLLECTION AUTHORITIES

Name:	<input type="text"/>	Contact Priority:	<input type="text"/>
Address:	<input type="text"/>		
Relationship to child:	<input type="text"/>		
Phone: (h)	<input type="text"/>	(w)	<input type="text"/>
(m)	<input type="text"/>		<input type="text"/>

Name:	<input type="text"/>	Contact Priority:	<input type="text"/>
Address:	<input type="text"/>		
Relationship to child:	<input type="text"/>		
Phone: (h)	<input type="text"/>	(w)	<input type="text"/>
(m)	<input type="text"/>		<input type="text"/>

N.B. It is very important that you tell these people that you have nominated them. In nominating them you give them authority to act on the child's behalf if neither parent can be located, to pick up the child in an emergency and care for the child until s/he can be returned home.

## COLLECTION AUTHORITIES ONLY

Name:	<input type="text"/>	Relationship to child:	<input type="text"/>
Address:	<input type="text"/>		
Phone: (h)	<input type="text"/>	(w)	<input type="text"/>
(m)	<input type="text"/>		<input type="text"/>

Name:	<input type="text"/>	Relationship to child:	<input type="text"/>
Address:	<input type="text"/>		
Phone: (h)	<input type="text"/>	(w)	<input type="text"/>
(m)	<input type="text"/>		<input type="text"/>

N.B. The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

Enrolment Form: Part 2

Child's Name:

**MEDICAL AND HEALTH INFORMATION**

Has the child received all immunisations appropriate for their age?  Yes / No

If no, please give details:

I accept full responsibility if my child is not immunised.  
Parent / Guardian signature:

Has the child received the following immunisations? (please tick):

12 - 13  
years

Diphtheria

Tetanus

Pertussis (Whooping Cough)

Human Papillomavirus (HPV)

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Has the child any conditions / medications that may be effected by OSHC activities?

If yes, please give specifics and any related medication:

Has the child any disabilities?  Yes / No      Effective date:

If yes, please record specifics:

Has the child any special needs?  Yes / No      Effective date:

If yes, please record specifics:

Does the child usually require special aids (e.g. glasses, hearing aid etc.)?

If yes, please give details:

Has the child any special dietary needs not related to allergies?

If yes, please give specifics:

Has the child suffered any illness that may re-occur (e.g. chronic ear infection)?

If yes, please give details:

Has the child had any kind of allergic reactions or food intolerances?

Foods:

Reaction / Medication:

Penicillin:

Reaction / Medication:

Others:

Reaction / Medication:

Is there any other medical information we might need to know?

Note: Please supply the service with required medications in original containers with the child's name clearly marked. Please complete a permission to administer medication form together with any medication records where necessary.

Usual Medical attendant

Doctor's name:

Phone No.:

Clinic name:

Address:

Usual Dental attendant

Dentist's name:

Phone No.:

Clinic name:

Address:

Medical Benefits cover with:

Ambulance cover with:

Medicare number:       Health Care Card number:

**Child's Name:**

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For bookings please complete a permanent booking form or contact the service on 0456 966 460 or [prospect.oshc@schools.sa.edu.au](mailto:prospect.oshc@schools.sa.edu.au)

BSC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

**From:**      /      /      **for:**      **weeks / or until:**      /      /      **or Ongoing (tick)** ☐

ASC	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Arrive:							
Depart:							

**From:**  /  /  **for:**  **weeks / or until:**  /  /  **or Ongoing (tick)** ☐

<b>VAC</b>	<b>Mon.</b>	<b>Tue.</b>	<b>Wed.</b>	<b>Thu.</b>	<b>Fri.</b>	<b>Sat.</b>	<b>Sun.</b>
<b>Arrive:</b>							
<b>Depart:</b>							

**From:**  /  /  **for:**  **weeks / or until:**  /  /  **or Ongoing (tick)** ☐

(e.g. 1. any personal, religious or cultural practices/prohibitions that you would like the service to know or 2. comments on homework, behaviour management etc.)

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There is no handwriting or other markings on the paper.

**Please initial next to each item to which you consent.**

I consent to Educators providing First Aid to my child. This includes but is not limited to the use of creams, lotions, saline solution or bandaids and bandages. First Aid kit contents is available upon request. Please indicate any allergies in the allergies section.

**I consent to Prospect Primary School OSHC and Prospect Primary School sharing medical records pertaining to my child.** ☐

**I consent to my child participating in supervised use of an ipad for approved educational game use and homework** ☐

**I consent for my child to be photographed and for their image and name to be published in circumstances appropriate to the Prospect Primary School OSHC rules and guidelines as necessitated by DfE.**

**I consent for Centre staff to apply sunblock to my child if required.**

**I give consent for OSHC staff to ring for an ambulance for my child in the event of a medical emergency and contacted immediately.**

**In other medical cases I understand I will be telephoned to be advised of the situation of any minor injury.**

**I understand an OSHC worker will apply basic first aid and advise me in due course.**

**I agree to pay the required fees for my child's booked childcare hours and accept the policies and rules of the Service.**

**I agree that the staff of the Service may administer simple first aid to my child if the need arises.**

**I understand that if at any time the staff of the Service consider that my child requires emergency medical/hospital/ambulance assistance, they will have the local medical/hospital/ambulance attend my child. I acknowledge that I will be liable for any medical/hospital/ambulance expenses incurred in the treatment of my child.**

**I certify that the information entered upon this form is true to the best of my knowledge and I undertake to inform the Service if any of these details change.**

Parent / Guardian signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

sighted a child health record (tick) ☐

Interviewed / Accepted by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_